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Submitted by the Zdrav*Reform* Program to:
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Moscow, Russia; Almaty, Kazakhstan; Kiev, Ukraine

SUMMARY

The overall purpose of Grant One is "to develop the conceptual framework, identify legal reforms and complete other preparatory acts for restructuring polyclinics (Policlinika) to form free standing primary care units staffed by family practice physicians."

At the end of fifteen (15) days in Barnaul, this consultant concluded that two models of managed health care are feasible in Altai-Krai under the subject grant. These two projects consist of 1) linkage of 4 polyclinics, and the Altai Diagnostic Center and hospitals yet to be determined in the city of Barnaul into one managed health care delivery system and 2) the establishment of another single managed care entity at Novoaltysk as a managed care entity serving the population of this city. This second project involves the dovetailing, to a certain extent, of Zdrav Grant One projects and Zdrav Grant Two projects.

Initial efforts however under Zdrav Grant One however are concentrated around the development of primary care practices with the five polyclinics of the applicant's area (i.e. four polyclinics in the city of Barnaul and one on the hospital campus in Novoaltysk).

The following significant obstacles exist to the realization of the above two projects. These include:

- Lack of available (i.e., in the field) managed care consulting expertise available on an as-needed basis
- Lack of project-oriented management awareness (including program goal, task, and activity planning, tracking and implementation)
- Changing political/payor/provider environment in Altai-Krai

Description of Consulting Assignment

The consulting assignment included the following deliverables. Onsite discussion with Abt-Moscow however allowed certain flexibilities with these deliverables. Although these consultant deliverables were included in the consultant contract they appear in fact to be the deliverables intended from the in-country Russian grantee. For Zdrav Grant one, the grantee is the Health Care Committee of Altai-Krai (Territorial Health Care Committee headed by Dr. Nikolaj Gerasimenko). These specific deliverables included:

1. Report describing a) the need for and the conceptual framework for polyclinic restructuring; and b) the impediments to restructuring that exist in the current legislation
2. Report describing recommended methods for open enrollment, quality assurance and for licensing and accreditation of general practitioners

3. Document describing procedures for open enrollment, quality assurance and accreditiation of general practioners.

4. Standard contracts to govern the working relationships between the free standing practice and the polyclinic.

5. Draft legislation and regulatory documents in Russian; approved by local authorities which allows and supports the formation of free-standing primary care practices staffed by self-managed family practice physicians.

6. Deliver Zdrav*Reform* publications discussed at the team planing meeting; most likely this will include a trip report, trip notes, and a summary description of the activity.

7. Conduct a debriefing with ZRP/Moscow office staff and USAID/Moscow staff.

Necessary Legal Changes

Draft enabling legislation as follows in the addendum. This legislation was developed in consultation with the grantee and translated and left onsite during the period of the in-country consultancy. Key points of this legislation include:

1. Enabling Legislation - It appears that enabling legislation is required in order to a) pay primary care polyclinics in a capitated way; b) pay for specialist services in a prepaid manner.

2. Tax freedoms - It is suggested that any polyclinic participating in this program be allowed the ability to retain a portion of its private income, free of taxes or rent to the Health Care Committee of up to 20% of its budget.

3. Risk Assumption - In addition, the ability of a health care provider to retain certain funds example from private pay patients should be fostered up to certain levels. For example, up to certain levels, e.g. 25% of an institutions' income could be tax or rent-free. After this level there would be a tax on profits but not on revenue.

4. Patient Choice Limitation - If in fact certain polyclinics are capitated there may exist two parallel systems, one for the "budget" patients and one for the "capitated" patients. The capitated patients may give up free access to specialty care that they essentially receive now in return for a free choice of primary care physician which they do not enjoy now.

   At the time of "enrollment" in the primary care project, the patient would be asked to sign a statement that in return for the ability to select the primary care physician, then he/she would agree that they would not be able to select a specialist without a

referral from the primary care physician. In turn the specialist would ensure that he had a referral in hand before seeing the patient or he might not be paid.

To effect these changes the following actions are recommended:

A. A Committee chosen by the Health Care Committee reviews the attached draft legislation with appropriate amendments.

B. A legislator is selected to introduce the legislation at the next meeting of the Altai-Krai legislature. This legislator will also be charged with any of the preliminary work necessary with key legislative members prior to the actual introduction and readings of the proposed legislation.

Necessary Financial Changes

Financial projections for polyclinic are premature until there is more structure to the initial setup of primary care physicians practices within existing polyclinics.

Items which must be considered include:

- Assumptions of how many physicians will be primary care physicians-presently projected at fifteen physicians in the pilot project
- What will happen to the therapists who do not become primary care physicians ("social guarantees")?
- Detail assumptions underlying financial plan
- Introduction of a territory-wide system of health care service measurement and coding e.g. Current Procedural Terminology

It appears that certain Management Information System activity is already underway through the work of Kevin Woodward already in Altai-Krai that would help support both financial oriented cost-finding as well as being the accumulation of actuarial data suitable for capitation development.

To institute capitation and risk incentive programs in the five demonstration polyclinics the following steps will need to be taken:

First, the present predominant payors, the Health Care Committee and the Territorial Health Fund must both have the legal capacity to and further agree to permit the capitation of providers (either primary or specialty or both) for the patients for which they have fiscal responsibility. At the time of the site visit, the Health Care Committee of Altai-Krai, and to a certain extent the Health Care

Committee of the Municipalty of Barnaul, have agreed without the apparent legal capacity to do so, to a capitation mechanism for primary care and possibly specialty care.

Onsite technical assessment and assistance of this visit concentrated on payments by the Health Care Committee and the Commitee of Barnaul. A similar model would need to be undertaken with the Municipalty Health Care Committee of Altai-Krai for the possible total capitation of the City Hospital campus (with related polyclinic) of Novoaltysk.

At the present time approximately 25% of the funding of the Health Care Committee of Barnaul goes toward polyclinic funding while 75% goes toward hospital funding.

Second, to accomplish the above financial oriented goals several tasks are necessary:

A. The Health Care Committee should research and detail what legal impediments exist to the establishment of the polyclinic restructuring. This could be accomplished either through appointing several people knowledgeable in contract and tax law to draft a report reviewing these legal impediments with suggested courses of action.

B. The output of this report (listed in A. above) will be used in the drafting of sample contracts between the following parties:

   Health Care Committee of Municipalities of Barnaul and Novoaltysk respectively and the polyclinics participating in this restructuring project

   Contract between the polyclinics and the primary care practitioner in each facilty

C. Establishment of the method and rate of payment of primary care practitioners will be done through consultation between the respective clinic administrators and the individual primary care practitioners with technical assistance from Abt Associates.

Necessary Health Services Delivery Changes

Although this consultant's expertise is in the area of managed health care finance, there are certain changes related to the area of finance which are necessary in the area of health services delivery. Elements needing work in future visits to this project include:

A. Credentialing of Health Care providers

   A procedure for the selection of which providers of the present therapists will be credentialled into the new primary care network must be instituted. In addition, this procedure should include future training and the delineation of relationships between the primary care group and the specialty referral physicians.

B. Contract or Agreement Between the Polyclinic Primary Care physicians and the polyclinic

Such an agreement would delineate the rights and responsibilties of each party as well as specify the rate of payment to these particular physicians

C. Delineation of Utilization Control Practices

What will be the methodology to ensure that only "proper" referrals are done to specialists?

Idea of Quality Assurance/Utilization Review Committee?

D. Creation of the Idea of Continuity of Care

The idea of the primary care physician being "in charge" of the patient after he leaves the care of the primary care physician to see a specialist is alien to the present Russian system. It is the desire of the Health Care Committee and most of the primary care physicians with whom I talked that they prefer the U. S. family practitioner model which supports this role of continuity of care.

E. Quality Asssurance

There appear to be no ongoing programs or organizational arrangements to carry out programs of quality assurance (i.e., methodologies for ongoing monitoring and evaluation of the quality of health care services including written procedures for appropriate remedial action whenever inappropriate or substandard services have been furnished, or services that should have been furnished but have not been furnished). Nor are there written guidelines for assessing the effectiveness of the corrective actions themselves or use of systematic data collection of performance and patient results, and the provision to providers of interpretation of data.

The methods for accomplishing this task will be created through consultation between the Health Care Committee of Altai-Krai and technical assistance of a physician under Abt Associates. Tasks that will be necessary include:

1) Creation and publication of a curriculum to train primary care practitioners;

2) Identifying and training the existing therapists who will be the first class of primary care practitioners (family practice physicians);

3) Creation of appropriate credentialing and committee structures to assure the continued quality of and improvement of the first class of primary care practitioners and subsequent classes.

Administrative and Managerial Challenges

Certain administrative and managerial challenges were noted in this initial consultancy that must be aggressively addressed as the project develops.

A. Data Issues

There is no procedural coding as known in the United States presently in use in Altai-Krai. The collection of patient data is reflected in the addendum in sample patient record information and in a sample fee survey from the Altai Diagnostic Clinic.

The project needs to immediately be furnished with samples from the United States Department of Health and Human Services, Health Care Financing Administration (HCFA) Resource Based Relative Value Scale (RBRVS); the Mc-Graw Hill Relative Value Unit (RVU) Schedule; and the latest example of the American Medical Association Current Procedural Terminology (CPT) coding system.

In regard to statistics on health status and medical utilization, the onsite review indicated that reliance on quantitative numbers in a formally centralized and planned economy is a bit foolish. The land of Potemkin and Nikolai Gogol's Dead Souls is not a place where **any** credence for example should be place on hospital occupancy statistics as confirmed in the two hospitals I visited in conjunction with association polyclinics. There quite simply is not baseline data to construct a capitation, other than by budgetary allocation.

Nonetheless, this consultant was favorably impressed with the capacity of Russian computer programmers to create sophisticated, elaborate relational data bases on rather low-capacity computers (US 286 and 386 chips). Careful consideration should be given to enhancing the "home-built" nature of Russian data bases rather than importing software. If project resources allow however, thought should be given to the purchase of "off-the-shelf" software capable of tracking claims and utilization data.

At least three copies of the latest Current Procedural Terminology should be shipped to the grantee as soon as possible.

B. Cost of Equipment

There may have been a serious underestimate by the grantee in the original grant request of the amount of funds necessary to fund the equipment for fifteen therapists (equipment includes exam tables, otoscopes, and other smaller hand instruments).

It is recommended that a detailed budget of each piece of equipment that will be purchased be prepared. This budget should include the following data items:

-Name and model of equipment
-Location of polyclinic where equipment will go
-Name of vendor for each piece
-Cost of each equipment piece
-Cost of shipping, taxes at point of origin, and taxes at point of receipt of the equipment
-Provisions for repair or replacement of items found defective or damaged

Strict inventory controls in accordance with AID grant regulations will need to be established with technical assistance from Abt.

C. General Project Management

Because of the wide number of activities that must be done in both clinical, financial, legal and general management areas, Dr. Valeri Elykomov who is managing day-to-day operations of the grant as well as his own responsibilities as Chief Therapist with the Health Care Committee of Altai-Krai should delegate certain responsibilities as noted above to task forces or special purpose committees. Such a delegation will allow central responsibility to stay with Dr. Elykomov while allowing for greater participation of affected parties and getting the grant responsibilities done in an orderly manner.

As the next step in this general project management, an output of the next technical assistance consultancy with the Zdrav Grant One project should be a detailed Gantt chart by functional area (e.g. tasks and activities necessary for legal, financial, health services delivery and general project management). Such a chart would detail the task necessary, who would be responsibile for each task, resources necessary, as well as the timing for the completion of the task. The use of the Gantt chart device would also allow for training in Western managerial techniques of complex projects.

Objectives and Operating Principles of Polyclinic Restructuring

The overriding primary objective of Zdrav Grant One is "to develop the conceptual framework, identify legal reforms and complete other preparatory acts for restructuring polyclinics (Policlinika) to form free standing primary care units staffed by family practice physicians."

A. Rationale for Clinic Restructuring

The primary payors for health care in the oblast of Altai-Krai and their respective responsibilties include the following:

Health Care Committee of Altai-Krai--Komitet Po Sdravoohraneniu
Health Care Committee of the Municipality of Barnaul

Health Care Committee of the Municipality of Novoaltysk
Mandatory Territorial Health Fund (of Altai-Krai)-Territorialny Fond Strahovaniya
Private (individual payors)
Private (direct factory/employer payors to providers)

It is important however to separate the political role of the above payors from their financial roles in a changing political and payor environment in Russia.

That changing environment has allowed the possibility of changing to a market-oriented economy in the purchasing of health services for appropriate market rewards for proper utilization of health care services (i.e. use of primary care services when specialty or hospital services are not medically needed)

The Health Care Committee of Altai-Krai, the grantee for both Zdrav Grant One and Two projects has in fact a very limited role as payor in the geographic areas of the municipality of Barnaul since June 1, 1994 and in the municipality of Novoaltysk from a date that has not been determined. However, the Health Care Committee of Altai-Krai has a substantial role as a policy setter and as a certification/licensure entity similiar to that of a State health department in the United States. Direct health care delivery is limited to the smaller cities within Altai-Krai as well as the large Territorial Hospital and Territorial Medical (Diagnostic) Center located in Barnaul.

The Health Care Committee of the Municipality of Barnaul has payment responsibility for all of the patients (unemployed, children, etc. category) in the four polyclinics proposed in this demonstration for primary care reform.

The Health Care Committee of Novoaltysk has similar payment responsibility in the fifth polyclinic proposed in this project.

B. Providers-Key Players in a New Health Market

All proposed polyclinic [policlinika] providers were visited during the site visit. These polyclinics included as follows:

<u>Municipality of Barnaul</u>

Polyclinic #1
Polyclinic #4
Polyclinic #9
Polyclinic #10-City of Usny

<u>Municipality of Novoaltysk</u>

Novoaltysk City Polyclinic

In order to design any quality reforms or market reforms it is necessary to understand the role of the polyclinic. What is a polyclinic? A polyclinic is generally a free-standing medical facilty in a neighborhood that serves as the initial entry point for accessing the formally centrally planned health care system. The polyclinic contains therapists [terapevt] (analagous but not identical to general practioners), as well as specialist physicians [vrach spetsialist] who may be otolarynthologists, obstetric-gynecologists, surgeons, etc. based upon the local population needs. Therapists (some of which are to be retrained and upgraded under this grant to primary care or family practice physicians) vary greatly in their training.

Staffing of the polyclinics is based on strict ratios that came from the formally centrally planned economic days. These ratios include one therapist per 2000 patients within the polyclinics geographic catchment area. It should be emphasized that patients *are assigned a therapist at their geographic polyclinic*. Patients currently have no choice of physician at their polyclinic. A choice of physician at the polyclinic would be a significant motivational feature for patients to change their way of accessing both primary care (formerly therapist care) and specialty care. Such a powerful motivation was repeatedly confirmed with both physicians and non-health care personnel encountered in Altai-Krai. A map of the participating clinics in this grant are is included in the appendix.

In addition, hospitals [Bolnitsa] associated with two of the polyclinics were visited. Polyclinic #10 has a hospital on the second and third floors of the polyclinic. The Novoaltysk City Polyclinic is located on the same campus as the Novoaltysk City Hospital.

It will be necessary to design a referral and hospital usage systems based upon the individual polyclinics having the newly trained primary care practitioners. Such a system would select (based upon quality and cost criteria) between all of hospitals in the area which include the municipal hospitals as well as former factory hospitals (approximately twenty-five in number) currently administered by either municipal health care committees or the Territorial Health Committee. The former factory hospitals are reputed to be among the those hospitals in the best physical condition.

In addition, there are certain specialty hospitals such as eye and maternity hospitals. The most sophisticated diagnostic equipment in the territory is encountered in the "Diagnostic Centers". The Altai Diagnostic Center would continue to be the source of highly specialized procedures that could not be done in the polyclinic and would not warrant a hospital visit.

C. Payors-Changing Players Cooperation is Critical

The Mandatory Health Insurance Fund (also referred to as the Territorial Fund) has been in existence for about one year. It appears that the establishment of this fund was intended only as an interim type of device until such time as private insurance companies might emerge to contract directly with payors (such as factories) as well as with providers such as polyclinics and specialty centers (such as Altai Diagnostic Center and the Territorial Health Center).

Anecdotal evidence indicates that approximately 70 insurance firms have petitioned to do business in Altai-Krai with only four being approved by the Mandatory Health Insurance Fund. *It is imperative that appointments be set up to meet with the Fund during the next onsite technical assistance in order to acertain their level of cooperation in these Barnaul and Novoaltysk primary care practitioner projects.*

The initial consultancy in February, 1995 identified the vision of the project in the minds of the grant recipient in lieu of a vision of the Country Action Plan which had not been approved as of the time of the consultancy. This vision is a two phased vision.

Phase one would include the following steps:

1. Creation of so-called "free-standing" family practioners/primary care physicians in five polyclinics. Elements of this "free-standing" aspect would include a designated area of the existing polyclinic to be renovated and equipped for the sole use of these new practioners (chosen from existing therapists at the rate of three per each of five polyclinics).

2. This phase would encourage the formation of primary care physicians while allowing for tax-free sheltering of income under the umbrella of the polyclinic.

3. Intensive training of the selected 15 therapists in curriculum similar to that of United States family practioners would be done over a three to four month period. This curriculum would be developed with the assistance of the Abt consultancy Devees (Deb) Brown, M.D. Dr. Brown was briefed by telephone by this consultant prior to his departure.

Phase two would move toward the creation of fee for services and eventually capitation as a means of payment to the primary care practices and also create the legal ability to capitate groups of specialists and hospitals.

Phase two is the most complex of the tasks. It would require the following resources:

1. Management information system technical assistance

   In order to pay on a fee-for-service basis or on a capitation basis, it is necessary to have a way of capturing data for both payment purposes and for utilization and quality assurance.

   It is recommended that a uniform data set for use in Altai-Krai and the other projects in Siberia be developed even prior to any implementation of automated data processing. A baseline of current data being collected in the medical records of polyclinics is attached in the Appendix

2. Risk and Incentive Systems

While the institution of a fee for service system would create the incentive of more pay for more work there also needs to be a be a counterbalance in the form of quality assurance and utilization review committees to assure that there is not inappropriate utilization. In addition, at some point in the future there should be set up separate primary care, specialty care, and hospital funds for each "group of patients", e.g. by polyclinic so that there would be the added incentive for a primary care practitioner to share in savings from the curtailment of inappropriate referrals to specialists or to a hospital.

3. Marketing

A detailed marketing plan needs to be written that would cover the following items:

-How will PCP's once they have been trained get patients?
-How will patients be informed of any rights to referral being given up by choosing to receive services from one of the newly trained PCP's?

Summary of Objectives and Operating Principles of Polyclinic Restructuring

Wide scale reform of the system can not be done until there is greater recovery of the economy. Substantial portions of industry are not paying into the Mandatory Territorial Health Fund [Territiorialny Fond Strahovaniya] due to reduced economic activity. However, the foundation of smaller scale reforms which can later be linked together through local initiatives would seem to be achieveable. Such smaller scale initiatives could include the creation of a cadre of true family practitioners (as differentiated from the current polyclinic "therapist"); the removal of legal impediments to the private contracting with those therapists; creation of clinic management systems to track both financial and utilization data and eventually the development of a capitated primary care practice.

APPENDIX

1. Polyclinic Medical Documents (Future Management Information System Data Elements)

Russian originals/English translations

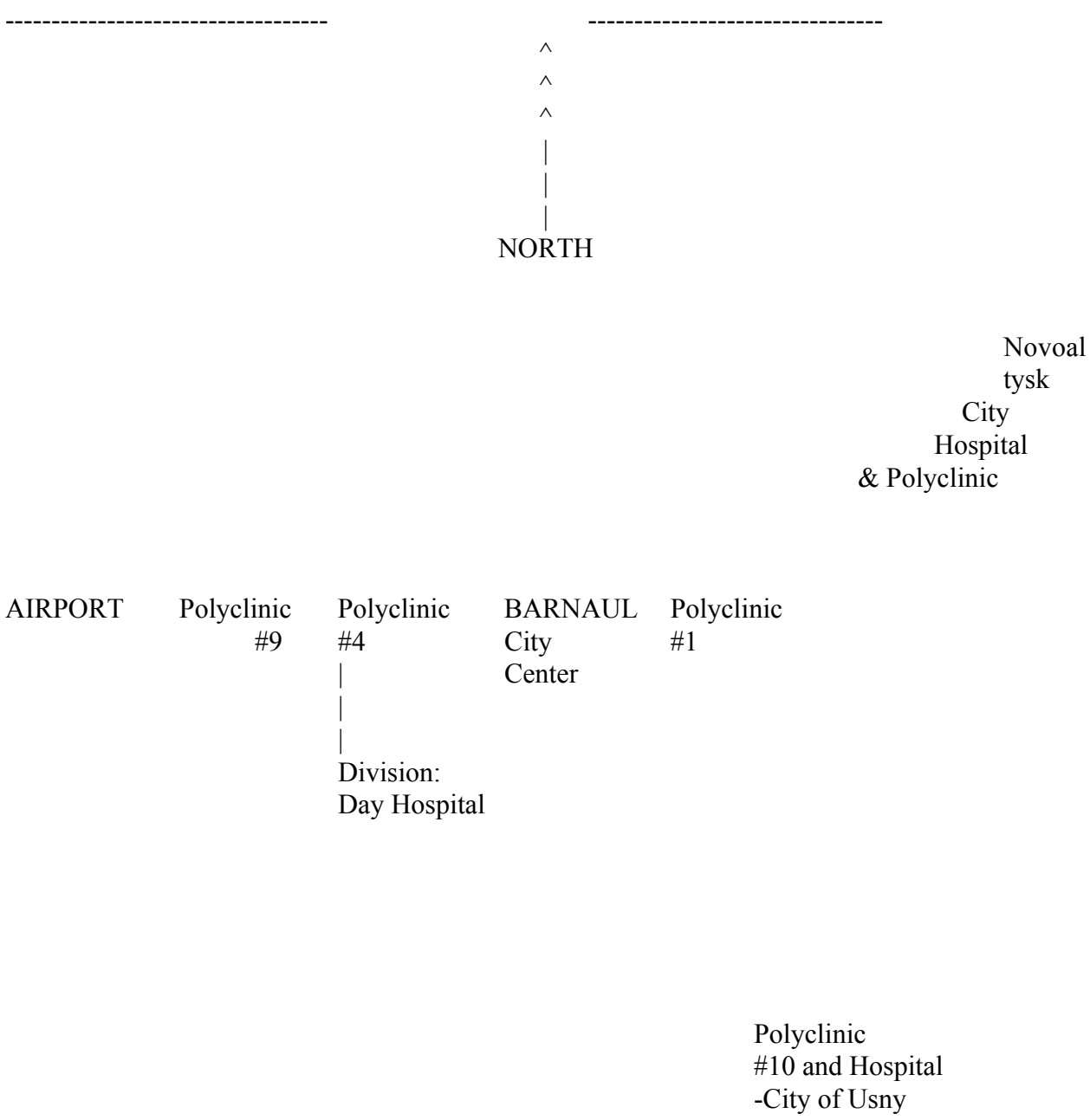
{English translation-requested of ABT before release of this report}

2. Sample fee schedule-Altai Krai Diagnostic Center

3. List of polyclinics and hospitals in Altai-Krai

   Requested in writing of Valery Elkymatov on February 17, 1995-not received as of day of departure

4. Schematic of Barnaul and Novolaltysk Polyclinics



5. Altai-Krai Officials Interviewed With Telephone Numbers

6. Draft Law Permitting Primary Care Capitation et al.

First Draft dated 2/23/94 by James R. Owens, Jr., U. S. Department of Health and Human Services, Health Care Financing Administration under USAID contract

First Draft Translation dated 2/25/94-translated into Russian by Yuri Piragov, Barnaul, Altai-Krai

A LAW TO IMPROVE THE HEALTH OF THE PEOPLE OF ALTAI-KRAI THROUGH THE TRAINING OF PHYSICIANS

I. The purpose of this law will be to improve the health of the people of Altai-Krai through changes to the present training and financing of polyclinic therapists.

II. In order to improve the health care delivery through polyclinics it is necessary that certain changes be made in the way polyclinic physicians are paid, how they are trained, and how people choose their physician.

III. It is anticipated that the creation of the specialty of primary care physicians based upon international standards will have as a result the increased usage of the polyclinic, with better coordination of the use of specialists with less usage of hospitalization.

IV. TRAINING OF PRIMARY CARE PHYSICIANS

1. This law will create a new category of physicians to be know as primary care physicians or family physicians.
2. The definition of a primary care physician is (to be developed):
3. The place of work of the primary care physicians shall be solely in the polyclinic.
4. Initially, the training of the therapist to become a primary care physician shall be the responsibility of the Territorial Health Care Committee. However, as soon as possible, but no later than January 1, 1996 the Territorial Health Care Committee shall transfer this responsibility to a Professional Association of Primary Care Physicians. In the event that primary care physicians fail to form such an association, than the responsibility for the training and designation of Primary Care Physicians shall remain the responsibility of the Health Care Committee.

V. PROFESSIONAL ASSOCIATION OF PRIMARY CARE PHYSICIANS

1. This law shall permit and encourage the formation of a professional association of primary care physicians.
2. The purpose of this association shall be to enhance the knowledge of the association members in the field of primary care, advocate the education of patients and the pubic in health matters, and to preserve the right of primary care practioners to

engage in medical and surgical procedures in which the members are qualified to conduct.

3. Effective January 1, 1996 the association of primary care phyiscians shall be the sole body that may confer the title "Primary Care Physician" upon any therapist. Prior to the establishment of the association of primary care physicians the designation of a therapist as a "Primary Care Physician" shall be the role of the Chief Therapist of the Territorial Health Care Committee acting with the advise of the chief doctor of the polyclinic of the doctor who is applying to become a "Primary Care Physician". The act of designating a Primary Care Doctor shall be called credentialling.
4. The association of primary care physicians shall be responsible for credentialling primary care physicians, designing training programs within the territory of primary care practioners, and in representing the primary care practioners at territory, national and international meetings.

VI. PAYMENT OF PRIMARY CARE PHYSICIANS

1. To encourage physicians to become primary care physicians the following changes shall be made in the method of payment of the primary care physician.

2. The primary care physician shall be paid a capitation amount based upon the number of patients assigned to him. The amount paid to the physician under capitation will always be in excess of the amount paid to a therapist because of the different manner in which the primary care physician will work.

3. The number of patients that a primary care physician (PCP) will be responsible for shall be at a minimum 2000 patients. The number of patients which choose a PCP will be known as the PCP's panel.

4. The PCP will be responsible for the management of the patients who have freely chosen to become a member of the PCP's panel. The PCP will be the sole authority to request a specialist consultation with the patient. The PCP will be the sole authority to authorize, after consultation with a specialist, the hospitalization of the patient.

5. The amount of the capitation payment to be made to the primary care practitioner may vary depending only upon the age, sex, and health status of the PCP's patient. All PCP patients of a similar age, sex, and health status shall receive the same capitation.

6. The capitation to be paid to the PCP shall be paid from the regular source of payment for the patient.

VI. PATIENT CHOICE OF PRIMARY CARE PHYSICIAN

1. To encourage patient choice of primary care physician certain principles shall be observed.
2. A patient who desires to use a primary care practitioner shall have complete freedom to select from any PCP at the polyclinic within his geographic area. A polyclinic shall not assign members to a PCP. The choice of a PCP shall be made by the patient only from the PCP's available at the patient's polyclinic.
3. If a patient chooses a PCP, that patient must agree in writing at the time of choosing the PCP, that he:
    a. Acknowledges the free choice to be able to choose the PCP;
    b. Will see a specialist only upon the written referral for consultation by the PCP to the specialist;
    c. Will not seek hospital care without the written approval of the PCP unless the patient has a life-threatening emergency. In such a case the patient may seek care from the closest hospital or emergency medicine doctor.
    d. Will cooperate with the PCP in achieving the highest health status possible that the patient is capable of. The patient is responsible for both following the orders of the PCP as well as avoiding those unhealthy behaviors that would endanger his health.

VII. ROLE OF POLYCLINICS

1. The use of PCPs in a polyclinic shall be initially limited to 3 PCPs in 5 polyclinics or a total of 15 PCPs available to serve a population of 2000 persons each or 30,000 members in total.

2. The choice of the polyclinics where PCPs will be designated shall be the sole choice of Chief Therapist of the Territorial Health Care Committee acting with the advise of the affected polyclinics.

3. To encourage the development of primary care physicians, any polyclinic participating in the PCP program shall have certain financial incentives. These incentives are as follows:

    a. All income to the polyclinic from the Mandatory Territorial Health Insurance Fund shall be 100% income to the participating polyclinic. No taxes or existing 60% rent fees shall be charge to the PCP participating polyclinics.
    b. All income to the polyclinic from private payment shall be free from taxation or other government levy, as long as the total revenue to the clinic from this source shall be less than 20% of the polyclinic's total revenue.
    c. All income to the polyclinic from direct contracts with factories or other enterprises shall be free from taxation or other government levy.

d. All income to the polyclinic from insurance funds other than the Mandatory Territorial Health Insurance Fund shall be free from taxation or other government levy.

VIII. RESPONSIBILITIES OF SPECIALIST PHYSICIANS AND HOSPITALS

1. It is the responsibility of each specialist and hospital in Altai-Krai to ascertain from the patient in writing whether is a PCP polyclinic patient.

2. If the specialist or hospital ascertains that the patient is a PCP polyclinic patient, it must contact the patient's PCP for permission to initiate treatment to the patient unless the patient is facing an immediate life-threatening emergency.

3. If a patient is treated by a specialist or hospital without ascertaining that the patient is a PCP polyclinic physician, then the Territorial Health Care Committee, the Health Committee of the Municipality of Barnaul, or the Mandatory Health Insurance Fund have full rights to deny payment a claim (bill) for services unless the specialist or hospital can prove it has written authorization from the PCP polyclinic to provide the service.

4. Specialist and hospitals may be permitted to also contract on a capitated basis with the following payors for health care: Territorial Health Committee, the Health Care Committee of the Municipality of Barnaul, the Mandatory Territorial Health Fund or other insurers on a capitated basis in a manner similar to the primary care physicians.

5. PCP Polyclinics shall be permitted to contract on a capitated basis with groups of outside (non-clinic) specialists, or with hospitals for those patients who have chosen to receive their care from the PCPs. Such a contract can be executed only if:
   a. The specialists or hospital, PCP, and the payor agree upon a capitated amount equal to the actuarial projection of future health care costs for a defined period for a defined group of patients.
   b. A data collection methodology exists to track the types of procedures being done by the specialists or hospitals
   c. The PCP polyclinic agrees to accept the financial risk for healthcare for those patients for which it is receiving a periodic capitation from one of the payors noted.

IX. DATA COLLECTION

1. Within 90 days of the passage of this law, the Territorial Health Care Committee shall assemble a Data Collection Working Group of fifteeen (15) members to study the following questions:
   a. Should a unique identification number be assigned PCP patients and/or all patients in Altai-Krai?

b. Should a uniform fee schedule for specialist physicians and hospital procedures be adopted in Altai-Krai?
(such a fee schedule might be based upon other fee schedules already in international use such as those used in the United States i.e. Current Procedural Terminology (CPT) of the American Medical Society; McGraw-Hill Relative Value Scale; or the Resource Based Relative Value Scale (RBRVS) of the U. S. Department of Health and Human Services/Health Care Financing Administration.

2. The fifteen members of this Data Collection Working Group shall be comprised of the following categories:
   a. Three PCP Polyclinic Physicians
   b. Six Specialists (both polyclinic specialists and other specialists)
   c. Three Hospital Physicians

3. The Data Collection Working Group shall issue a report with recommendations no later than 120 days after the committee is chosen.

III. Description of the Altai-Krai Medical Environment-Separating Payors, Providers, and Politicos

Vision of the Project

The grantee is the Health Care Committee of Altai-Krai (or "Territorial Health Care Committee" headed by Dr. Nikolaj Gerasimenko. Day to day operational responsibility for this grant is handled by Dr. Valeri Elykomov, Chief of Therapists [terapevts] of the Health Care Committee. As of the date of this consultancy there was not always a consistent vision of the project from the perspective of both Gerasimenko and Elykomov. However, onsite technical assistance from this consultant and from Igor Sheiman (ABT-Moscow) has helped clarify some of these issues.

The vision of Elykomov is a two phased vision. [It is important to note that as of the date of this consultancy the final version of the Zdrav Grant One had not been seen by this consultant.]

Phase one would include the following steps:

1. Creation of so-called "free-standing" family practioners/primary care physicians in five polyclinics. Elements of this "free-standing" aspect would include a designated area of the existing polyclinic to be renovated and equipped for the sole use of these new practioners (chosen from existing therapists at the rate of three per each of five polyclinics).

2. This phase would be to encourage the formation of primary care physicians while allowing for tax-free sheltering of income under the umbrella of the polyclinic.

3. Intensive training of the selected 15 therapists in curriculum similar to that of United States family practioners would be done over a three to four month period. This curriculum would be developed with the assistance of the Abt consultancy Devees (Deb) Brown, M. D. Dr. Brown was briefed by telephone by this consultant prior to his departure.

Phase two would move toward the creation of capitation as a means of payment to the primary care practices and create the legal ability to capitate groups of specialists and hospitals also.

A. Momentum

The project appears to have gathered considerable momentum due to the actual signing of the grant, onsite technical assistance from consultant experts, and from Abt-Moscow. This momentum should not be lost. To keep this momentum going the follow challenges need to be faced early and perhaps "re-faced" often.

B. Onsite Planning, Organizing, and Development

Much of the onsite work of this project is being handled it appears by Dr. Valeri Elykomov. Dr. Elykomov, while young is visionary and politically astute but has not had, I believe, the opportunity to manage such a large scale project. In addition, he has no staff to my knowledge. Training in various management tools such as Gantt charts, grant budgeting, and progress reports should be given to him and perhaps, to additional assistants of his choosing by Abt-Moscow.

There exists the real possibility Dr. Elykomov may be swamped by the number of activities unless he is assisted with certain management tools to help him manage this project, one of many he has.